STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING _____ B. WING _____	12/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation numbers 27692, 27730, 27744, and 27966, conducted on December 4-6, 2011, at NHC Healthcare Smithville, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	The following constitutes our allegation of compliance. This plan of correction is submitted under state and federal law. The submission of this plan does not constitute and admission on the part of NHC Healthcare as to the accuracy of the surveyor's findings nor the conclusion drawn therefrom. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to honor a resident's right to refuse treatment for one resident (#5) of twenty-eight residents reviewed. The findings included: Resident #5 was admitted to the facility on January 19, 2011, with diagnoses including Multiple Sclerosis, Morbid Obesity, and Depression. Medical record view of the Minimum Data Set (MDS) dated October 5, 2011, revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status (BIMS-no cognitive impairment) and required extensive assistance with eating. Medical record review of a physician's order	F 155	Patient # 5's dietary preferences were reviewed with her by the Director of Nursing on 12/9/11. A teaching record regarding the possible negative outcomes of not following her recommended diet was completed by the Director of Nursing with the patient on 12/9/11. The physician was notified of the patient's wishes and a new diet order was received on 12/9/11. Nursing and dietary staff were notified on 12/9/11 of this change and to follow the patient's wishes for her diet. All other in-house patients were interviewed on 12/13/11 by the Director of Nursing designee to ensure that they felt like their preferences were being followed. No other patients were found to be affected. An in-service concerning patient's rights and their right to refuse treatment were begun on 12/13/11 for all staff. This in-service will be complete by 12/15/11. A QA concerning patient's rights will be conducted by interviewing 10% of the centers residents. This QA will be conducted by the Director of Nursing or her designee. This QA will begin on 12/19/11 and will be conducted once a week for four (4) weeks, then once a month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Services Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	12/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admr — (X6) DATE: 12/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 dated October 27, 2011, revealed, "...feed pt (patient) only three (3) meals a day - if (resident) wishes more (resident) must feed it to (self)...no in between meals snacks...needs to be on a 1800 cal (calorie) (or less) diet w/ (with) < (less than) 60 gm (grams) of fat divide calories into 3 meals w/ no snacks..." Medical record review of a nurses' note dated November 29, 2011, revealed "...patient complains X2 (times two) days of not receiving snacks patient reminded of diet order..." Medical record review of a nurses' note dated December 1, 2011, revealed "...pt (patient) argumented (argumentative) about diet et (and) MD (Medical Doctor) order of 1800 calorie diet. Pt still continues to request snacks after dinner..." Medical record review of a dietary progress note dated December 1, 2011, revealed "Resident continuing to voice complaints about current diet order of 1800 cal or less diet/ <60 grams of fat divided into 3 meals no snacks. Discussed breakfast menu and cal per each item. Will not be sending any snacks. Told resident if MD order changes dietary will abide by those changes. Will serve lunch and supper items in accordance c (with) the reduced calorie spreadsheet..." Observation and interview with the resident on December 4, 2011, at 12:25 p.m., and 3:01 p.m., and December 5, 2011, at 9:55 a.m., and 11:25 a.m., in the resident's room, revealed the resident's physician ordered a reduced calorie diet because the resident was "fat" and had a "fatty liver". Further interview revealed the resident understood the ordered diet but did not	F 155		

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F 155	Continued From page 2 want to be on the ordered diet. Further interview revealed the resident had told the physician, the director of nursing (DON), and the dietician the resident did not want to be on the ordered diet, but the facility refused the resident's requests for any foods or snacks not within the ordered diet. Interview with Registered Nurse (RN) #3 on December 5, 2011, at 9:06 a.m., outside the resident's room, confirmed staff were not providing any snacks the resident requested. Interview with the Registered Dietician (RD) on December 5, 2011, at 10:20 a.m., in the 300 hall chart room, confirmed the RD was aware the resident did not want the ordered diet but the facility was following the physician's order, not providing any foods outside the ordered diet, and not providing any snacks the resident requested. Interviews with the RD on December 5, 2011, at 10:20 a.m., in the 300 hall chart room, and the DON on December 5, 2011, at 10:31 a.m., in the DON office, confirmed the resident's right to refuse a physician's ordered diet had not been honored.	F 155		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	The MDS for patient # 1 dated 9/26/11 was corrected on 12/13/11 to reflect her ability to assist in her own meal intake. The MDS for resident # 3 dated 8/31/11 was corrected on 12/13/11 to reflect her history of fracture to her hand. A review of all other current in-house MDS's was completed on 12/14/11 by the MDS Coordinator. No other patients were found to be affected.	12/14/11

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F 278	Continued From page 3 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure the Minimum Data Set (MDS) was accurate for two residents (#1 and #3) of twenty-eight residents reviewed. The findings included: Resident #1 was admitted to the facility on June 28, 2011, with diagnosis including General Muscle Weakness, Lack of Coordination and Dementia. Medical record review of the MDS dated September 26, 2011, revealed the resident required total dependence for eating.	F 278	An in-service on MDS accuracy was conducted by the Director of Nursing for the MDS team on 12/14/11. A QA regarding the accuracy of MDS assessments will be conducted by reviewing 10% of in-house MDS's. This QA will be conducted by the Director of Nursing or her designee. This QA will begin on 12/19/11 and will be conducted once every week for four weeks and then once every month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Service Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	

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F 278	Continued From page 4 Medical record review of the Care Plan dated October 3, 2011, revealed the resident is a dependent diner. Observation on December 4, 2011, at 12:15 p.m., in the Reflections Dining Room, revealed the resident sitting at the dining room table eating with no assistance from staff. Interview on December 4, 2011, at 12:30 p.m., with the Assistant Director of Nursing (ADON) in the Reflection Dining Room, confirmed the resident feeds self and requires assistance from the staff to complete the meal. Interview on December 5, 2011, at 2:15 p.m., with Certified Nurse Assistant (CNA) #1, in the Activity Room, on the Reflection Unit, confirmed the resident feeds self seventy-five percent of the time or greater and becomes agitated if staff attempts to feed the resident. Interview on December 5, 2011, at 3:00 p.m., with Registered Nurse (RN) #1, at the Intermediate Care Facility (ICF) Nurses' Station, confirmed the resident feeds self and the MDS dated September 26, 2011, was not accurate. Resident #3 was admitted to the facility on November 22, 2005, with diagnosis including Alzheimer's Disease, Dementia, and Anxiety. Medical record review of the MDS dated August 31, 2011, revealed the resident had experienced three falls with no bone fracture. Medical record review of the Post Fall Nursing	F 278		

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F 278	Continued From page 5 Assessment dated June 30, 2011, revealed the resident had a fall. Further medical record review of a hand x-ray dated July 1, 2011, revealed "...fifth metacarpal shaft fracture..." Interview on December 5, 2011, at 9:23 p.m., with the Director of Nursing (DON), at the ICF Nurses Station, confirmed the resident had a fall on June 30, 2011, with a hand fracture and the MDS was not correct.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the physician's order for two residents (#11 and #17) of twenty-eight residents reviewed. The findings included: Resident #11 was admitted to the facility on November 3, 2010, with diagnosis including Dementia with Behaviors, Bipolar Disease, and Anxiety. Medical record review of a Psychiatric Services recommendation dated August 30, 2011, revealed a recommendation from the Advance Practice Nurse (APN) to the patient's physician, to add "...Trileptal (for bipolar disorder) 150mg (milligram) at 2pm daily..." Continued medical record review revealed the recommendation was	F 281	Patient number 11 was assessed on 12/14/11 by the Director of Nursing with no ill effects found. Patient number 17 was assessed on 12/19/11 by the Director of Nursing with no ill effects found. On 12/14/11 psychiatric nurse practitioner recommendations along with active medication orders were reviewed by the Director of Nursing and her designee. All orders were implemented timely. No other residents were found to be effected. On 12/14/11 all licensed staff was in-serviced regarding the timely implementation of medication orders. A QA regarding the timely implementation of medication orders will be conducted utilizing 10% of in house patients. This QA will be conducted by the Director of Nursing then once every month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing , the Health Information Manager, the Social Service Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	12/30/11

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F 281	Continued From page 6 reviewed by the physician September 2, 2011, and the physician agreed. Medical record review of the Medication Administration Record dated September 6, through September 30, 2011, revealed the facility failed to implement the physician's order until September 7, 2011, resulting in five missed doses of the Trileptal 150 mg. Interview on December 5, 2011, at 9:17 a.m., with the Director of Nursing (DON), at the Intermediate Care Facility (ICF) Nurses' Station, confirmed the facility failed to implement the physician's order resulting in five missed doses of the Trileptal 150mg. Resident #17 was admitted to the facility on June 14, 2011, with diagnosis including Alzheimer's Disease, Dementia, and Congestive Heart Failure. Medical record review of a Physician Order dated November 14, 2011, revealed "...Bumex (diuretic) 1 mg. daily..." Medical record review of the Medication Administration Record dated November 1, 2011, through November 30, 2011, revealed the first dose of Bumex 1 mg. was administered on November 16, at 9:00 a.m. Interview on December 6, 2011, at 2:30 p.m., with Licensed Practical Nurse (LPN) #1, at the ICF Nurses' Station, confirmed the Bumex 1 mg was not administered on November 15, 2011, at 9:00 a.m.	F 281		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 7 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy/procedure review, and interview the facility failed to provide appropriate incontinence care for one resident (#1) of twenty-eight residents reviewed. The findings included: Resident #1 was admitted to the facility on June 28, 2011, with diagnosis including General Muscle Weakness, Lack of Coordination and Dementia. Medical record review of the Minimum Data Set (MDS) dated September 26, 2011, revealed the resident was totally dependent on the staff for cleansing self after elimination and always incontinent. Observation on December 4, 2011, at 1:10 p.m., in the resident's room, revealed two Certified Nurse Assistants (CNAs) providing hygiene care	F 315	Patient #1 was assessed and proper incontinence care was provided on 12/4/11. All other in-house patients were assessed on 12/5/11 by the Director of Nursing designee for proper perineal care and no other patients were found to be affected. An in-service regarding appropriate incontinence care was begun on 12/13/11. This in-service will be completed by 12/16/11. A QA regarding appropriate incontinence care will be conducted by assessing 10% of the centers in-house patients. This QA will be conducted by the Director of Nursing or her designee. This QA will begin on 12/19/11 and will be conducted once a week for four (4) weeks, then once a month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Service Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	12/16/11

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F 315	Continued From page 8 following an episode of bowel and bladder incontinence. While performing perineal care, CNA #2 cleaned resident's perineal area, wiping from front to back, and then wiped the resident's perineal area front to back three times, using the same cloth visibly soiled. Review of the facility's policy and procedure, titled Perineal Care, revealed "...wipe from front to back...using each wipe only once..." Interview with CNA #2 on December 4, 2011, at 1:10 p.m., in the resident's room, confirmed the perineal area was wiped front to back three times using the same visibly soiled cloth. Interview with the Assistant Director of Nursing (ADON), on December 4, 2011, at the Intermediate Care Facility (ICF) Nurses' Station, confirmed incontinence care was not provided according to the facility policy.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	Resident # 10 was assessed on 12/14/11 by the Director of Nursing will no ill effects noted. Resident # 11 was assessed on 12/14/11 by the Director of Nursing with no ill effects noted. Resident # 18 was assessed on 12/14/11 by the Director of Nursing with no ill effects noted. On 12/14/11, pharmacy recommendations were reviewed by the Director of Nursing for unnecessary medication use and none were found. All physician orders were implemented timely. Pharmacy recommendation will be obtained from the physicians and implemented timely to assure unnecessary drugs will not be given.	12/14/11

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F 329	Continued From page 9 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement physician's orders timely, resulting in unnecessary medication doses for three residents (#10, #11, and #18) of twenty-eight residents reviewed. The findings included: Resident #10 was admitted to the facility on October 19, 2007, with diagnosis including Dementia, and Depression. Medical record review of a pharmacy recommendation dated November 8, 2011, revealed a recommendation by the pharmacy, to the attending physician/prescriber to discontinue Megace (appetite stimulant) 40 mg. (milligram) BID (twice daily) Continued medical record review revealed no documentation the recommendation was reviewed until November 11, 2011, when the physician agreed with the recommendation. Medical record review of the Medication Administration Record dated November 1, 2011,	F 329	On 12/14/11 licensed staff was in-serviced on timely implementation of physician orders to assure unnecessary medications are not given. A QA regarding the timeliness of implementing physician's orders will be conducted utilizing a 10% sample of in-house patients. This QA will be conducted by the Director of Nursing or her designee. This QA will be conducted once every week for four weeks, then once a month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Service Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	12/14/11

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F 329	Continued From page 10 through November 30, 2011, revealed the facility failed to discontinue the medication until November 14, 2011, resulting in six unnecessary doses of Megace 40 mg. Interview with the Director of Nursing (DON) on December 5, 2011, at 3:10 p.m., at the Intermediate Care Facility (ICF) Nurses' Station, confirmed the delay in implementing the physician's orders resulted in six unnecessary doses of Megace. Resident #11 was admitted to the facility on November 3, 2010, with diagnosis including Dementia with Behaviors, Bipolar Disease, and Anxiety. Medical record review of a pharmacy recommendation dated November 8, 2011, revealed a recommendation by the pharmacy, to the attending physician/prescriber to discontinue Marinol (appetite stimulant) 2.5 mg. BID (twice daily) Continued medical record review revealed no documentation the recommendation was reviewed until November 11, 2011, when the physician agreed with the recommendation. Medical record review of the Medication Administration Record dated November 1, 2011, through November 30, 2011, revealed the facility failed to discontinue the medication until November 14, 2011, resulting in six unnecessary doses of Marinol 2.5 mg. Interview with the Director of Nursing (DON) on December 5, 2011, at 9:17 a.m., at the Intermediate Care Facility (ICF) Nurses' Station, confirmed the delay in implementing the	F 329		

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F 329	Continued From page 11 physician's orders resulted in six unnecessary doses of Marinol. Resident #18 was admitted to the facility on October 29, 2008, with diagnosis including Alzheimer's Disease, Dementia, and Anxiety. Medical record review of a Physician Telephone Order dated November 11, 2011, revealed "...Mucinex (expectorant) 600mg. BID (twice daily) for 7 days..." Medical record review of the Medication Administration Record dated November 1, 2011 through November 30, 2011, revealed the facility failed to discontinue the medication until November 25, 2011, resulting in six unnecessary doses of Mucinex 600 mg. Interview with Licensed Practical Nurse #1 on December 6, 2011, at 2:30 p.m., in the ICF Nurses' Station, confirmed six unnecessary doses of Mucinex was administered.	F 329		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to provide a safe environment for one resident (#2) of twenty-eight residents reviewed.	F 465	Resident #2's bed was replaced on 12/4/11. All other patient's beds were evaluated by the Maintenance Supervisor on 12/9/11. No other patients were found to be affected. An in-service regarding timely repair of patient equipment was conducted by the Director of Nursing on 12/14/11.	12/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING _____ B. WING _____	12/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166

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F 465	Continued From page 12 The findings included: Resident #2 was admitted to the facility on November 29, 2011, with the diagnoses including Diabetes Mellitus, Hypertension, Multiple Sclerosis, Inner Ear Disease, and Personal History of Fall. Medical record review of the Nursing Admission Assessment dated November 29, 2011, revealed the resident was alert and oriented and required one person to assist with transfers and ambulation. Interview with the resident on December 4, 2011, at 9:39 a.m., in the resident's room, revealed "...my bed doesn't lock...a couple of days ago my bed slipped with me while the CNAs (Certified Nurse Assistants) was helping me to the bathroom and we almost fell." Interview with CNA #6 and observation of the resident's bed on December 4, 2011, at 9:40 a.m., in the resident's room, confirmed the bed continued to move from side to side while in the locked position. Interview with CNA #7 on December 4, 2011, at 3:25 p.m., in the hallway outside the resident's room, revealed, "...Thursday night (December 1, 2011) me and a nurse were assisting (the resident) when the resident's bed moved even though it was in locked position." Interview with Licensed Practical Nurse #8 on December 5, 2011, at 7:59 am, in the 300 Hall, confirmed a CNA reported on December 4, 2011,	F 465	A QA regarding the timely repair or replacement of patient equipment will be conducted by reviewing 10% of the in-house patients. This QA will be conducted by the Director of Nursing or her designee. This QA will begin on 12/19/11 and will be conducted once every week for four weeks then once every month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Services Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	

DEPARTMENT OF HEALTH AND I AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 13 the bed would not lock. Further interview revealed maintenance was notified and the bed was replaced. Further interview confirmed maintenance issues are logged in a maintenance book unless it is a safety issue, such as a bed not locking, which would be reported directly to maintenance for immediate repair. Interview with the Maintenance Director on December 6, 2011, at 8:55 a.m., in the lobby, confirmed the bed locks needed repair and maintenance was not informed until December 4, 2011 (three days later).	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to ensure the medical record was accurate for one resident (#1) of twenty-eight residents reviewed.	F 514	The medical record for resident # 1 was updated on 12/6/11 to reflect the accurate allergy information for that resident. A review of all in-house patient's medical records was conducted on 12/13/11 by the Director of Nursing designee to ensure that their medical records reflected accurate allergy information. No other patients were found to be affected. An in-service regarding medical record accuracy and allergy information was conducted by the Director of Nursing on 12/13/11. A QA regarding medical record accuracy and allergy information will be conducted by reviewing 10% of the in-house patients' medical records. The QA will be conducted by the Director of Nursing or her designee. This QA will begin on 12/19/11 and will be conducted once every week for four weeks, then once a month for two months and as directed by the QA committee which includes the Medical Director, the Administrator, the Director of Nursing, the Health Information Manager, the Social Services Director, the Assistant Director of Nursing, and the Director of Rehabilitation.	12/13/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 14 The findings included: Resident #1 was admitted to the facility on June 28, 2011, with diagnosis including General Muscle Weakness, Lack of Coordination and Dementia. Medical record review of the chart tab Condition Alert no date, revealed an orange sticker "...Allergies...NKDA (no known drug allergies)..." Medical record review of the Physician's Active Orders Recap dated October 25, 2011, revealed "...Allergies: Demerol and Haldol..." Interview on December 4, 2011, at 12:48 p.m., with Licensed Practical Nurse # 3, at the Intermediate Care Facility (ICF) Nurses' Station, confirmed the resident had an allergy to Demerol and Haldol and the medical record was not correct.	F 514		